THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-6480.M5

MDR Tracking Number: M5-04-1052-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 12-11-03.

The IRO reviewed therapeutic activities, muscle testing, hand muscle testing, physical medicine procedures, ROM measurements, cardiovascular procedures, therapeutic exercises, paraffin bath therapy, body muscle testing and office visit rendered from 12-11-02 through 04-16-03 that was denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 03-02-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
2-4-03	99243	$120.00 (1 unit)	$0.00	F	$116.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
2-4-03	95834	$120.00 (1 unit)	$0.00	G	$116.00	Rule 133.307 (g)(3)(A-F)	Not global to any other procedure billed on date of service. Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
2-4-03	95851	$40.00 (1 unit)	$0.00	G	$36.00	Rule 133.307 (g)(3)(A-F)	Not global to any other procedure billed on date of service. Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
TOTAL		$280.00	$0.00				The requestor is not entitled to any reimbursement.

This Decision is hereby issued this 4th day of May 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 12-11-02 through 04-16-03 in this dispute.

This Order is hereby issued this 4th day of May 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
RL/dlh

March 1, 2004
Amended March 4, 2004

MDR Tracking #: M5-04-1052-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

On ___, ___'s right middle finger was caught in gears of equipment, causing open fracture of the finger. He underwent ORIF with skin graft, occupational therapy and home ROM exercises. Eventually he developed avascular necrosis of the ulnar condyle of the PIP joint. Subsequent deviation deformity developed. Right 3rd digit PIP joint arthroplasty was performed. The treating doctor referred him for an FCE, which revealed the patient's inability to resume his original duties. Additional skilled active rehabilitation was performed and ultimately the patient progressed to a point where he was able to engage in a work hardening program. He also underwent at least two sessions of chronic pain counseling.

DISPUTED SERVICES

Under dispute is the medical necessity of therapeutic activities, muscle testing, hand muscle testing, physical medicine procedures, ROM measurements, cardiovascular procedures, therapeutic exercises, paraffin bath therapy, body muscle testing, and office visits provided from 12/11/02 through 4/16/03.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

This patient had a severe right 3rd digit open fracture requiring two separate and distinct procedures. He underwent ORIF initially, developed avascular necrosis and underwent PIP joint arthroplasty. The patient had documented pain and weakness of the hand which did require additional skilled active rehabilitation. The documentation provided for review supports that the patient progressed to a point where work hardening was appropriate. Additional skilled active rehab and work hardening for this patient was consistent with acceptable standards of care.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,